Adult Mental Health Block Grant FY 2008 - 2010

CRITERION 1: Comprehensive Community-Based Mental Health Service Systems

Freedom Commission Goals:

Goal 1: Mental Health is Essential to Health: *Every individual, family and community will understand that mental health is an essential part of overall health.*

Goal 2: Early Mental Health Screening and Treatment in Multiple Settings*: Every individual will have the opportunity for early and appropriate mental health screening, assessment, and referral to treatment.*

Goal 3: Consumer/Family Centered Care: *Consumers and families will have the necessary information and the opportunity to exercise choice over the care decisions that affect them.*

Goal 4: Best Care Science Can Offer: *Adults with serious mental illness and children with serious emotional disturbance will have ready access to the best treatments, services, and supports leading to recovery and cure. Accelerate research to enhance prevention of, recovery from and ultimate discovery of cures for mental illnesses.*

Transformation Activities:
Reduce stigma associated with mental illness
Prevent suicide
Improve coordination of care among multiple systems
Assure individualized plans of care for all consumers
Develop culturally competent services
Align financing for mental health services for maximum benefit

Mental Health Services

Montana State Hospital (MSH) is the only state-run inpatient psychiatric hospital. The hospital provides short-term emergency care as well as extended treatment for adults admitted in accordance with civil involuntary and criminal court (forensic) procedures. Patients are admitted from across the entire state of Montana, often following a short stay in a psychiatric unit in a community hospital, or in a community crisis stabilization facility. State law governs admission and discharge procedures.

The hospital works closely with contracted care coordinators and mental health providers across the state to coordinate care and to return individuals to their home communities for appropriate aftercare services. The hospital has a median length of stay of 44 days for people discharged following civil commitments. Criminal commitments generally have much longer stays.

Goal	Recommendation	MSH Action
1. Understanding that mental health is essential to overall health	1.1 - Reduce stigma and develop strategy for suicide prevention	Training on use of "person-first" language to help address stigma

	1.2 - Address mental health with same urgency as physical health	Provide MSH patients comprehensive physical healthcare services and develop wellness and prevention programs
2. Mental health care is consumer and family driven	2.1 - Develop individualized plan of care	Every patient has an individualized treatment plan and discharge plan
	2.2 – Involve consumers and families in orienting the system toward recovery	A) MSH has an active Resident's Council that has been recognized as one of the best in the country B) MSH is employing peer support specialists C) MSH has a family support specialist to provide education and outreach to patient families
	2.3 – Align federal programs to improve access	MSH employs an enrollment specialist to help people access services and benefit programs upon discharge
	2.4 - Create a comprehensive state mental health plan	MSH has a plan for services that has aligned its treatment programs with five clinical pathways
	2.5 - Protect and enhance the rights of people with mental illness	MDBOV and MAP are actively engaged with hospital staff on the MSH campus. MSH has also implemented procedures to greatly reduce the use of restraint and seclusion procedures.
3. Eliminate disparities in mental health services	3.1 - Improve access to culturally competent care	Information on providing culturally appropriate treatment services has been provided to MSH staff
	3.2 – Improve access to care in rural areas	MSH is the only mental health service provider serving the entire state
4. Early mental health screening, assessment, and referral services	4.1 – Promote the mental health of young children	The MSH Family Support Specialist helps families with young children visiting

		at MSH
	4.2 – Improve and expand school mental health programs	
	4.3 – Screen for co-occurring mental and substance use disorders and integrate treatment	Assessment of chemical dependency and abuse are part of routine assessment procedures. Comprehensive CD and co-occurring treatment is provided.
	4.4 - Screen for mental disorders in primary health care	Our physical health physicians are active treatment team members
5. Excellent mental health care is delivered and research is accelerated	5.1 - Accelerate research to promote recovery	University of Montana Doctoral Candidates in Psychology have been conducting research into treatment outcomes at MSH
	5.2 - Advance evidence-based practices and demonstration projects	MSH has played a leadership role in Dialectical Behavioral Therapy (DBT) and Co-Occurring treatment within Montana's Public Mental Health system
	5.3 - Improve and expand the workforce	MSH has been very successful in attracting qualified professionals including psychiatrists, psychologists, and nurses
	5.4 – Develop the knowledge base in understudied areas	MSH has provided many staff members with training in trauma informed care and other important topics.
6. Technology is used	6.1 – Improve access through technology	MSH has long used televideo systems to help coordinate care with the community and to reduce transportation needed for court appearances
	6.2 – Implement an electronic health record	MSH is implementing the TIER electronic medical record system and enjoys close collaboration with the Healthcare Informatics

		program at Montana Tech

Montana State Hospital direct care staff consists of: 15 social workers; 7 psychologists; 1 psychologist specialist; 9 psychiatrists; 137 psychiatric technicians; 8 recreation technicians; 8 recreation specialists; 5 recreational therapists; 1 occupational therapist; 2 peer specialists; 44.75 RN nurses; and 31 Licensed Practical Nurses. The average daily census for FY 2006 was 199. There were 691 admissions during the year and about the same number of discharges. The hospital is certified for participation in the federal Medicare and Medicaid programs.

Montana Nursing Care Center (NCC) is the state-operated nursing care facility for individuals with mental disorders. The Center provides long-term care and treatment to people who require a level of care not available in communities or who will not benefit from intensive psychiatric treatment available at Montana State Hospital.

Montana's community-based mental health services are provided by a variety of local agencies including licensed mental health centers, independent private practitioners, and short-term psychiatric inpatient units in community hospitals. The community psychiatric inpatient units are located in Kalispell, Missoula, Billings and Great Falls.

Licensed mental health centers provide the majority of the outpatient care for the adult population who qualify for Medicaid or Mental Health Services Plan (MHSP). Five mental health centers provide the majority of services. Four of the five centers serve a multi-county region and each participating county appoints one commissioner to the center's governing board. Each governing board includes a primary consumer, a family member of a consumer, either a parent or a child with an emotional disturbance, and either a person representing the interests of the elderly or a health care professional. A.W.A.R.E., Inc., the fifth provider has offices state wide but adult services are primarily located in Glendive (group home only), Butte, Bozeman, and Great Falls. Smaller mental health centers in Missoula and Billings serve a small number of clients. The five licensed mental health center providers are as follows:

Eastern Montana Community Mental Health Center (EMCMHC) serves seventeen counties in the eastern-most part of the state. This is a huge land area (48,588 square miles) with a population density of less than 2 people per square mile. This service area, which is larger than many states (service area is larger than the state of Pennsylvania), is bordered by Canada on the north, North and South Dakota on the east, and Wyoming on the south. The Center's service area includes two large Native American reservations, the Fort Peck Reservation to the north, headquartered in Poplar; and the Northern Cheyenne Reservation to the south, headquartered in Lame Deer. The Native American population comprises approximately 7 percent of the total population of this service area and 13% of the Center's caseload.

EMCMHC offers some level of services in all seventeen counties, although some communities are served on a part-time basis by staff traveling from offices in other counties. Targeted case management for adults is available throughout the entire service delivery area. Day treatment services for adults with severe mental illness are provided in Miles City, Glendive, and Sidney. Adult residential programs (an adult group home and adult foster care) are located in Miles City. Services provided are: medication management; outpatient services; community rehabilitation

and support; emergency services; education and consultation; and substance abuse and dependency. Eastern Montana uses the Telemedicine Network extensively to provide services to rural areas. The Telemedicine Network makes psychiatric care available to all citizens of Eastern Montana and is being used for education and group sessions. The Telemedicine Network is presently serving Miles City, Glendive, Sidney, Culbertson, Colstrip, Baker, Glasgow, Plentywood, Scobey, Wolf Point, Malta, Forsyth, and Poplar.

Center for Mental Health Services serves a twelve-county area in north central and southwest Montana. The two largest communities in the region are Great Falls (population 56,215) and Helena (population 27,885). Both have well-developed community support systems under the leadership of the mental health center including a coordinated program of day treatment, targeted case management, outpatient psychotherapy, medication management, supported employment, transitional and residential living (group home, semi-independent living, adult foster care), and Program for Assertive Community Treatment (PACT) services. Psychotherapy services are available in ten of the twelve counties of the service delivery system and targeted case management is available in all twelve counties. Medication review in the smaller satellite offices is on a consultation basis by psychiatrists based in Great Falls and Helena.

South Central Montana Regional Mental Health Center provides services in a twelve-county region in south-central Montana. Their administrative offices are located in Billings.

The Mental Health Center provides comprehensive services in Billings including psychiatry, psychotherapy, day treatment, adult residential services, program for assertive community treatment (PACT), intensive case management, PATH program, and drop-in services. The center works collaboratively with the Montana Department of Corrections and Department of Veterans Affairs. Two major community resources are the Billings Clinic, which has the state's largest psychiatric unit for short-term inpatient acute care and Rimrock Foundation, which provides crisis stabilization services and is also a state approved alcohol and drug provider.

The mental health center is a founding partner (along with St. Vincent's Healthcare; Billings Clinic; and Yellowstone City-County Health Department) of the Community Crisis Center in Billings. The Community Crisis Center provides outpatient assessment and referral and helps divert unnecessary presentations at area emergency rooms.

In addition, Billings Clinic Behavioral Health (consisting of 9 full-time psychiatrists) partners with the Mental Health Center and two private practice psychiatrists to provide on-call and psychiatric services to Billings and the Eastern region.

The Mental Health Center provides a mental health social worker for the Case Management Team for the Home and Community Based Waiver for individuals with SDMI. The social worker is under contract with the Yellowstone City-County Health Department for services provided through the HCBS waiver.

Western Montana Community Mental Health Center (WMMHC) serves fifteen counties in western and southwestern Montana. The area is the most populated region of the state with a density of more than ten people per square mile. WMMHC has worked to provide a

comprehensive service system in Missoula, Butte, and Kalispell. Each of these communities has PACT, psychotherapy, day treatment, targeted case management, psychiatric services, mobile crisis and crisis residential services. Kalispell Regional Hospital and St. Patrick Hospital (Missoula) each have inpatient psychiatric units. WMMHC provides psychotherapy and case management services in the other twelve counties in the region. WMMHC also provides medication monitoring to outlying communities by psychiatrists who travel from Missoula, Bozeman, and Kalispell.

A.W.A.R.E., Inc. provides targeted services to a subset of adults with serious mental illness and development disabilities; young adults transitioning into adult mental health services; and persons who meet nursing home level of care. The services include targeted case management, intensive community-based rehabilitation, and psychiatric services including medication management. Services are provided in Butte, Great Falls, and Glendive (group home services only).

Co-Occurring Initiative

The Addictive and Mental Disorders Division has continued to contract with Dr. Ken Minkoff and Dr. Chris Cline to provide technical assistance in the development and implementation of a comprehensive and coordinated service array and integration of services to adults with co-occurring disorders. The Montana Co-Occurring Disorders Policy Team and the Montana Change Agents are two groups of providers and other stakeholders that meet quarterly to review progress and plan the next implementation steps. The Change Agents and Policy Team members also work in statewide workgroups to address a variety of topics related to Co-Occurring Capability.

Each of the four comprehensive community mental health centers are state approved alcohol and drug programs in some communities within their regions. All other state approved alcohol and drug programs are required to contract with a mental health center to provide appropriate services for clients who have a co-occurring mental illness.

Employment, Rehabilitation and Educational Services

Each of the mental health centers either has a vocational specialist on staff or has an agreement with the local vocational rehabilitation office. These persons help clients identify what they are most interested in pursuing and match those interests with the person's capabilities. This includes both education and vocational services. Many persons complete their GEDs and some consumers have gone on to take college classes and obtain degrees. The centers have supportive employment as well as competitive placements.

AMDD has a cooperative agreement at the state level with the Montana Vocational Rehabilitation (MVR) Services Program. This long-standing agreement outlines their commitment to both supported and transitional employment programs and has been in place since the inception of supported employment in Montana. While these agreements have served to define terms of service, and provide general guidance regarding the execution of employment services, both AMDD and MVR are committed to strengthening these relationships and

increasing the incidence of successful, meaningful employment outcomes for persons with mental illness. To that end the agencies will strengthen service provision in Montana by providing technical assistance to local service communities for the purpose of developing local Cooperative Agreements that reflect a commitment to building stable, sustainable return to work programs utilizing the coordinated assets of AMDD and MVR.

The Department received funding from the Department of Labor to develop the infrastructure within the Department to allow persons to work and keep Medicaid. Fear of losing Medicaid is the primary barrier for persons returning to work.

Transformation of Mental Health Services

The Dialectical Behavior Therapy (DBT) Steering Committee has an ongoing training and peer consultation plan. This is a service proven effective for the treatment of individuals who are traditionally consumers of high cost mental health and emergency services. DBT Services are available in eight Montana communities as well as the Montana State Hospital, Montana Women's Prison, and Montana Chemical Dependency Center.

There are five established Programs of Assertive Community Treatment (PACT) in Montana, and a new team was formed in July of 2007. Established teams may serve up to 70 clients. Each team has state funding for 10 – 14 consumers who are eligible for the Mental Health Services Plan. PACT team leaders across the state have a monthly conference call to provide support and training for one another. Team members receive training and consultation related to individuals with co-occurring disorders. Montana teams strive to achieve high fidelity to the PACT model, although the teams experience challenges related to workforce shortages, as do all other mental health agencies in Montana.

Montana has incorporated strength based and recovery oriented services in the mental health system. During FY2007, the first peer support services were developed in Great Falls and Hamilton. During FY2008, MHSB will support development of additional peer initiatives across the state, including leadership training for consumers to acquire skills to support active involvement in the community.

The Mental Health Oversight Advisory Council (MHOAC) has included peer services as one of their three goals. MHOAC consists of over 50% consumer and family members, making the council uniquely qualified to research, direct, and assist in the development of consumer driven services. The Council received technical assistance from National Association of Mental Health Planning Advisory Council (NAMHPAC) on various models on peer services at its November 2005 meeting.

Mental Health Services Bureau (MHSB) provided funding for twenty persons to attend facilitator training for Wellness Recovery Action Plan (WRAP) in February 2007. Over 100 persons have received training in WRAP in Miles City, Great Falls, Butte, Bozeman, Choteau, Havre, and Billings. WRAP training is a covered service for those enrolled in the Home and Community Based SDMI Waiver. MHSB and MHOAC plan to sponsor a Leadership Academy Training in the winter of 2008.

Service Area Authorities and Local Advisory Councils

Montana is continuing to support the development of three Service Area Authorities (SAAs): Eastern, Western and Central. All three SAAs are incorporated and registered with the Secretary of State. The boards are required to have 51% consumer and family member representation. The SAAs provide guidance to the MHSB for service development and planning for the State's mental health system. The SAA's played a significant role in providing information to legislators and AMDD during the 2007 Legislature and share credit for successful outcomes for new programs and an increased appropriation. Some of the goals of the SAAs for the upcoming year include, continue work on their strategic plan and long range planning with AMDD. There are 29 Local Advisory Committees across the state: the Central SAA has 8 serving 15 counties, and the Western SAA has 7 serving 13 counties and the Eastern SAA having 13 serving 27 counties. Due to the expanse of the ESAA, the use of video-conferencing has reduced extensive travel costs. MHSB continues to provide the financial and technical support to sustain the SAA system.

Strengths Based Case Management

MHSB continues to support the implementation of strengths based case management in Montana. All of the mental health centers have received strength based case management training. In cooperation with the Chemical Dependency Bureau training is being provided to chemical dependency programs on reservations. Currently, White Sky Hope of Chippewa Cree have received training and there are plans for the Crystal Creek Lodge of the Blackfeet to receive training in fall 2007.

All mental health centers are required to provide recovery for clients receiving case management services. The recovery markers measure objective outcomes for people who are working towards recovery. The recovery markers are indicators of health and well-being that measure clinical domains, such as symptom severity and interference, as well as recovery domains, such as housing and employment.

Activities to Reduce Hospitalization

Admission to Montana State Hospital is a judicial process, and the professional staff at the facility does not conduct a pre-admission review or exercise any decision-making authority over the medical necessity for admission. The hospital is licensed for 189 beds, but its census frequently exceeds the licensed capacity. AMDD contracts with First Health Services for two adult care coordinators who work closely with the hospital to ensure more successful community placements. These coordinators are familiar with the community resources across the state and work cooperatively with community providers to creatively wrap those services around persons discharged from the state hospital to help ensure a successful transition to community services.

The 2007 Legislative session approved 2.5 FTE Community Liaison Officer positions. This proposal provides for five halftime employees who will be based in the community to mentor current and recently discharged patients from Montana State Hospital, assure that these consumers are able to get to referred services, and provide assistance in accessing needed services, supports, and resources in the community. The goal is to provide community support for meeting the recommendations of the hospital discharge plan and re-integrating into the community. It is anticipated that these positions will be filled with primary consumers who can provide a unique perspective on recovery and community reintegration.

Other projects approved by the 2007 Legislature are 72 hour presumptive eligibility for individuals in crisis, an expansion of the Mental Health Services Plan (MHSP), Behavioral Health Inpatient Facility (BHIF); and suicide prevention. The 72 hour crisis stabilization will provide 72-hour presumptive eligibility and payment for crisis stabilization services in the community setting, and enhance the use of telemedicine services to increase availability of mental health professionals on a 24/7 basis. The MHSP expansion proposal provides for additional funding for MHSP, state funded mental health services for adults who are not eligible for Medicaid, have incomes under 150% of federal poverty level, and who have been determined to have a severe disabling mental illness. The BHIF proposal provides for one time only funding in the second year of the biennium. The BHIF is a sixteen or fewer bed facility that provides a secure site for inpatient treatment. It may be either a free standing facility or attached to a hospital. It is intended as a community alternative for patients who would otherwise be transported to the state hospital. The suicide prevention proposal provides funding for a suicide prevention officer who will coordinate all suicide prevention activities conducted by the Department and other state agencies.

Homelessness

The mission of the Governor's Council on Homelessness is: "To *develop and implement strategies to prevent and reduce homelessness in Montana overall and to end chronic homelessness by 2014."* The Council has been in existence since June 2004. Most recently, the Council has begun looking at strategies designed to impact this complex issue as a whole. These strategies include creating a single definition of homelessness in Montana as well as creating common standards for meeting the needs of homeless persons, including prioritizing them and agreeing not to release anyone into homelessness.

SSI/SSDI Outreach, Access and Recovery (SOAR) training has been offered to all case managers and supervisors in mental health and substance abuse agencies and Health Care for the Homeless staff. A total of four trainings have been offered in Helena, Missoula, Billings, and Whitefish with over 100 persons trained.

Waivers

The 2005 Legislative session authorized the Department to apply for the Medicaid Health Insurance Flexibility and Accountability (HIFA) waiver. The proposal was submitted to CMS in June 2006. If approved, the Department can implement the waiver in FY 2008. The proposal would secure Medicaid financing for a portion of the state-funded Mental Health Services Plan (MHSP) that currently provides mental health services and pharmacy benefits to approximately

2,200 people per month who have a severe disabling mental illness but are not eligible for Medicaid. The waiver would enhance the quantity, quality and range of services available to persons with severe disabling mental illness. The service improvements would include: $1.3 million per year in additional funding for the existing Mental Health Services Plan; a physical healthcare benefit for approximately 1500 MHSP recipients a month, who currently do not have health care coverage; $200,000 per year in Medicaid funding for short term in-patient acute psychiatric benefit; and $240,000 of community block grant to address other system of care issues. Under the waiver, the beneficiaries will have the ability to choose the physical health care benefit that best meets their needs.

AMDD has received approval from the Centers for Medicare and Medicaid Services (CMS) for a home and community based waiver for adults age 18 and over with severe disabling mental illness (SDMI) who, without the waiver services, would be in nursing homes. The SDMI waiver is not available statewide and there is a capacity for 105 slots. An additional 20 slots were approved by the 2007 Legislative session. The SDMI waiver is operational in Billings (and surrounding counties); Great Falls (and surrounding counties); and Butte (including surrounding counties). The waiver team in each core site consists of a nurse who contracts with Senior Long Term Care Division and subcontracts with a social worker from a mental health center who will provide case management services. The SDMI waiver services include case management, Wellness Recovery Action Plan (WRAP), Illness management and recovery program, non-medical transportation, specialized medical equipment and supplies, personal emergency response system, adult day health, respite, private duty nursing services, day habilitation, prevocational services, supportive employment, additional occupational therapy, adult residential care, habilitation aide, chemical dependency counseling, residential and day habilitation, supported living, personal assistance and specially trained attendants, psychosocial rehabilitation, and case management.

Medical and Dental

Each community mental health provider is responsible for assessing the medical and dental needs of each client. Those persons with Medicaid are easily served for their medical needs. However, dental care continues to be an ongoing problem for all persons with Medicaid. Persons with MHSP are served through public health clinics and federally qualified clinics that provide medically necessary services for physical and dental health. Medications and limited medical care have been accessed through the federally qualified clinics and Health Care for the Homeless clinics.

Housing Services

Western Montana Mental Health Center has a full time housing developer. This person has been on staff since the early 1990s. The center has numerous housing options available in the Missoula area. They include: Single Room Occupancy (SRO) apartments, apartments, group homes, detoxification unit, half way house for co-occurring, housing units for women and children, and condominiums available for home ownership. The housing specialist has assisted other communities such as Butte, Hamilton, and Kalispell in obtaining housing options.

South Central Mental Health Center in Billings has group homes with onsite supervision and one cooperative living facility in which case managers check on residents instead of an onsite supervisor. The Center has good relationships with the Housing Authority and landlords. The Mental Health Center has received PATH technical assistance in developing a housing project. The center is developing a proposal for a Safe Haven for the 2007 Continuum of Care application. A Billings Council, appointed by the local mayor, is a pilot project under the Council on Homelessness to develop a housing plan for the community.

A.W.A.R.E., Inc. has a fulltime housing developer. They have adult group homes available in Butte, Glendive and Great Falls. The group home housing has followed the universal design and appears as a duplex with common community areas. They have a capacity of eight persons for each home.

Community mental health centers utilize shelter plus care vouchers that allow persons with mental illness to access housing in addition to the services available in the community. The communities of Billings, Missoula, Helena, and Butte have access to these vouchers through the public housing authorities. In addition, the mental health centers in Missoula and Helena have their own shelter plus care vouchers. A total of 170 shelter plus care vouchers are available with an additional 131 vouchers were requested in 2007.

The Department of Commerce, Housing Division has received twelve shelter plus care vouchers. These vouchers are available directly to PATH programs to manage. This is a pilot project is developing a collaborative relationship between the Department and the Department of Commerce. Presently, five persons are placed using the shelter plus care vouchers. They are in Bozeman, Kalispell, Great Falls, Butte and Billings. Kalispell, Bozeman, and Great Falls have never had access to shelter plus care vouchers.

The MHSB is an active member of the Governor's Council on Homelessness. In addition, Division staff members are serving on workgroups addressing housing, special needs population, and access to and delivery of mainstream services.

Corrections and Mental Health

In July 2006, the Department of Public Health and Human Services and the Department of Corrections jointly hired the state's first Behavioral Health Program Facilitator to act as a liaison between these two culturally diverse departments. This position has been created to assist the movement of offenders through the criminal justice, mental health and substance abuse treatment systems; facilitate communication between the DOC and DPHHS, and to ensure the lasting, systemic change policymakers will need to improve upon initial cooperative efforts, begin to collaborate and, ultimately, enter into partnerships.

The mission statements of the partners are:

Department of Corrections
The Montana Department of Corrections enhances public safety, promotes positive change in offender behavior, reintegrates offenders into the community and supports victims of crime.

Department of Public Health & Human Services
Our mission is to improve and protect the health, well-being, and self-reliance of all Montanans.

The mission of the ***Addictive and Mental Disorders Division*** (AMDD) of the Montana Department of Public Health and Human Services is to implement and improve a statewide system of prevention, treatment, care, and rehabilitation for Montanans with mental disorders or addictions to drugs or alcohol.

The failure of the public mental health system to connect effectively endangers lives, wastes money, and threatens public safety – frustrating crime victims, consumers, family members and communities in general. A shared and consistent treatment modality will support and enable diversion from secure correctional facilities and inpatient mental health facilities; and will provide linkages for appropriate aftercare services upon discharge.

Offenders with mental illness typically face these challenges:

1. They have psychiatric illnesses and substance abuse disorders that can helped by the provision of appropriate treatment and rehabilitation services, but are often not connected with community based health care service providers
2. They have psychiatric illnesses and substance abuse disorders that can be helped by the provision of appropriate treatment and rehabilitation services.
3. They frequently lack basic life skills, such as the ability to socialize and maintain relationships with others. Acquiring these skills is essential in fostering recovery from mental disorders.
4. They are commonly disconnected from family, the community, and other forces that motivate pro-social behavior and provide support when people's resources are inadequate.
5. They suffer the double-stigma of having a mental illness and being a criminal offender.

Incarceration alone is not the answer, it protects the public for a period of time, but it does not provide the offender with needed treatment and support to increase the likelihood of successful community reintegration.

The long term goals are:

1. Joint planning and evaluation of services for offenders with mental illness occurs between the two departments

2. Transitions among programs and into the community are seamless and well integrated with regard to mental disorder and addiction treatment services.

3. Communication between the two departments is clear, consistent and reaches to all levels of staff and programs.

4. Process and outcome data points have been jointly defined, commissioned, collected and analyzed to evaluate the impact of services provided by the collaborating agencies to the target population.

5. Programs for offenders with mental illness are designed to utilize shared assets between the two departments and provide for efficient use of limited resources.

6. A formal inventory exists of all services available to the target population, including those outside the scope of the collaborative initiative. Partner agencies have coordinated their response to gaps in service capacity and identified opportunities to guide the initiative with current services or supports.

7. To create consistent, evidence based treatment methods across systems between the Department of Corrections and the Department of Public Health and Human Services.

Two programs were approved by the 2007 State Legislature. They are the mentally ill offender drug program and services for mentally ill offenders. The mentally ill offender drug program is a pharmacy benefit modeled on the Mental Health Services Plan (MHSP) for participants who are not eligible for publicly funded benefit programs but still require medication support. The program will expand the psychotropic medication upon discharge and provide crisis funds for participants who may have become unstable and need medication due to specific life events. The program will provide a pharmacy bridge which provides medication during the benefit enrollment period. The target population are offenders leaving secure custody for placement in Department of Corrections Community Corrections Division programs or facilities that have been determined to have serious mental illness and who have not been enrolled in public benefit programs. $950,000 general fund dollars are available for the program in FY 2008 only.

The second project is the services for mentally ill offenders. The target population will be individuals with mental illness and co-occurring substance use disorders that are: released from correctional institutions, state hospital, or currently under the supervision of the Community Corrections Division. Treatment providers will be located in regional probation/parole offices and/or prerelease centers to offer mental health treatment, case management and to assist offenders with medication monitoring. Other program elements include: an incentive payment will be offered for up to 30 prerelease beds per year; coordination of transition plans for offenders leaving secure custody to community based supervision programs; assist offenders with serious mental illness in applying for available benefit programs; and training programs for probation and parole officers in the areas of mental health and addictions. $371,647 per year is available for services.

The Mental Health Oversight Advisory Council identified “improved access to mental health treatment for mentally ill prisoners” as one of its top three priorities. This area was identified in part due to the fact the forensic population is the fastest growing population at the state hospital. The Council will focus primarily on those returning to communities in need of mental health treatment, although there is interest in diversion activities and mental health courts.

Transition Services

The Department of Public Health and Human services has convened an intradepartmental service coordination workgroup. The group meets monthly to work on developing a process for providing services across divisions to individuals who are dually diagnosed, TBI, children and adults. The immediate tasks of the group include developing a Memorandum of Understanding

and mission statement, establishing a budget process, identifying individuals before they are in crisis, and a process to ensure key players are involved in discharge planning.

Montana was one of six states involved in the 2005-2007 National Governors Association Policy Academy to Improve Outcomes for Young Adults with Disabilities. To ensure the State's participation results in systemic change, the Governor convened a task force to work toward creating a comprehensive, cohesive transition system. The task force includes representatives from many state agencies, universities, advocacy organizations and young people with disabilities. AMDD's Administrator and Mental Health Bureau Clinical Program Manager are members of this task force.

Goal One: Increase consumer self direction with community mental health services.

Indicator One: Increase the percentage by 2% each year of those adults with SDMI that report participation in their treatment planning.

Measure: Numerator: The number of respondents who answered "Agree" or "Strongly Agree" to two survey questions that relate to involvement of the respondent in treatment planning.
Denominator: The total number of adult respondents these two questions.

Source of Information: Statewide aggregate data from the Consumer Satisfaction Survey.

Significance: Taking on that responsibility increases feelings of self-esteem, self worth, dignity and self-respect and increases sense of responsibility for self care.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	72%	72%	74%	76%	78%
Numerator	404	449			
Denominator	565	628			

Indicator Two: Increase the percentage by 1% each year of those adults with severe mental illness that report positively about their outcomes with mental health services.

Measure: Numerator: The number of respondents who answered "Agree" or "Strongly Agree" to six survey questions relating to outcomes.
Denominator: The number of respondents to these access questions.

Source of Information: Statewide aggregate data from the Consumer Satisfaction Survey.

Significance: Consumer choices and responsibility for self care moves the process to recovery and positive outcomes.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	62%	60%	62%	63%	64%
Numerator	309	333			
Denominator	500	556			

Indicator Three: Increase the percentage by 1% each year of adults with severe disabling mental illness that rate the access to services positively.

Measure: Numerator: The number of respondents who answered "Agree" or "Strongly Agree", to six survey questions relating to access, on a five point response.
Denominator: The total number of adult respondents to the six access questions.

Source of Information: Statewide aggregate data from the Consumer Satisfaction Survey.

Significance: Successful access creates a greater potential for positive outcomes.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	76%	76%	77%	78%	79%
Numerator	424	477			
Denominator	558	624			

Indicator Four: Develop at least one new peer/recovery service each fiscal year. *(Transformation indicator)*

Measure: The number of programs providing or operating peer/recovery services.

Source of Information: The number of services provided.

Significance: The community mental health providers have not used peer support services in any organized fashion. The addition of peer services will provide additional capacity for community services.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	1	2	3	4

Goal Two: **To provide quality community mental health services. (Transformation Goal)**

Indicator One: Increase the number of evidence based practices (EBPs) available for persons served in the adult mental health system over the next two years. *(Transformation indicator)*

Measure: The number of evidence-based practices that adhere to SAMHSA identified fidelity scales.

Source of Information: Annual review of service arrays and applicable fidelity scales.

Significance: EBPs improve outcomes for persons with SDMI.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	2	2	2	3	4

Indicator Two: Increase the number of persons receiving services that are Evidence Based Practices. *(Transformation indicator)*

Measure: Number of persons receiving EBPs in full accordance with SAMHSA adopted fidelity scales.

Source of Information: Paid claims data base from MMIS.

Significance: The use of Evidence Based Practices improves outcomes for consumers served.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	338	356	371	386	401

Indicator Three: Add Illness Management and Recovery evidence based practice. *(Transformation indicator)*

Measure: Programs offering service.

Source of Information: Reports from mental health programs.

Significance: Continues efforts to transform the Montana mental health system toward a recovery focus.

Fiscal Year	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	30	50	70

Indicator Four: Develop and maintain signed work/employment service agreements between MVR local authority and the local community mental health providers.

Measure: The number of signed service agreements.

Source of Information: Copies of the signed service agreements on file at MHSB.

Significance: Employment is essential to recovery and person centered treatment.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	2	2	3	4	4

Indicator Five: Improve collaboration with local providers and tribal governments.

Measure: Number of meetings/contacts.

Source of Information: The contact logs from the Community Program Officers.

Significance: Services that are culturally sensitive have improved outcomes for Native American consumers and family members.

Fiscal Year	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	48	55	60	65

Indicator Six: Continue development of co-occurring capable services.

Measure: Numerator: The number of mental health and chemical dependency providers using Zialogic or Integrated Dual Diagnosis Treatment Tools for assessment of co-occurring capability (IDDT Fidelity Scale, COMPASS, or CODECAT).

Performance Indicator: Total number of providers to whom the tools were made available.

Source of Information: Report from the Division.

Significance: Addressing these issues in an integrated manner provides more effective treatment.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	17	18	20	22	24

Goal Three: To support recovery and community integration. (Transformation Goal)

Indicator One: Increase the number of clients receiving self-contained treatment from PACT.

Measure: Percent of clients who receive self-contained treatment from PACT.

Significance: As an evidence-based practice, this program has improved outcomes for participating consumers.

Fiscal Year	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	76%	78%	80%	82%

Indicator Two: Continue Dialectic Behavioral Therapy (DBT) programs in community, Montana Chemical Dependency Center (MCDC), Montana State Hospital (MSH), and Montana Women's Prison.

Measures: The number of beneficiaries participating in DBT.

Source of Information: Authorizations and paid claims data (mental health centers only).

Significance: Access to DBT provides consumer choice and promising practice for those persons with Mood Disorders and Borderline Personality Disorders.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	49	41	45	50	55

Indicator Three: Continue the Wellness Recovery Action Plan (WRAP) trainings.

Measure: Number of trainings conducted.

Source of Information: Information provided by the organization that administers WRAP training across the state.

Significance: WRAP is a wellness tool that is essential for the recovery of persons with serious mental illness.

Fiscal Year	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	10	15	25	30

Indicator Four: Continue the Home and Community Based Waiver.

Measure: Number of persons receiving waiver services – 105 slots in SFY2007, 125 slots in SFY2008.

Source of Information: MMIS data system.

Significance: The HCBS waiver allows persons with serious mental illness to choose to receive services either in the community or in a nursing home.

Fiscal Year	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	29	125	125	125

Indicator Five: Increase awareness of mental health and mental illness in Montana.

Measure: Anti-Stigma presentations.

Source of Information: Contact logs from Community Program Officers.

Significance: Public education increases the opportunity for individuals with serious mental illness to live and work in the community.

Fiscal Year	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	52	60	65	70

Indicator Six: Investigate attitude instruments.

Measure: Report on feasibility of instruments.

Source of Information: Quality assurance section report

Significance: This is the first step in developing a method to assess awareness of and attitudes towards mental disorders in the State of Montana. Through understanding the general public's views on mental health issues, the Division can address educational needs in communities, leading to increases in prevention and people seeking treatment.

Indicator Seven: Develop peer to peer programs.

Measure: Number of peer to peer programs available.

Source: Report from programs.

Significance: Use of peers increases the capacity to serve individuals. As evidence based practice, improved outcomes are expected.

Fiscal Year	FY 2007 Target	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	2	3	4	5

Goal Four: Improve the continuity of care and community reintegration.

Indicator One: Decrease the percentage of persons discharged from the Montana State Hospital who are readmitted within 30 days of discharge each year.

Measure: Numerator: Number of adults readmitted to the MSH within

30 days.
Denominator: Total number of MSH discharges.

Source of Information: Admission/discharge data from MSH.

Significance: Rapid recidivism may reflect ineffective community programs, very serious illness, premature discharge, or noncompliance.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	7%	8%	7%	6.5%	6.5%
Numerator	45	48			
Denominator	676	667			

Indicator Two: Decrease the percentage of persons discharged from the Montana State Hospital who are readmitted within 180 days of discharge each year.

Measure: Numerator: Number of adults readmitted to the MSH within 180 days.
Denominator: Total number of MSH discharges.

Source of Information: Admission/discharge data from MSH.

Significance: Rapid recidivism may reflect ineffective or inadequate community programs, very serious mental illness, premature discharge, or noncompliance.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	17%	20%	17%	16.5%	16%
Numerator	114	134			
Denominator	676	667			

Indicator Three: Contract for a study to be completed in FY 2008 of the readmissions to the Montana State Hospital.

Measure: Recommendations made to the Division regarding the increased readmission rates.

Source of Information: Report to the Division.

Significance: An identification of the factors that contribute to re-admission will provide valuable information for system planning.

Indicator Four: Increase collaboration with the Montana State Prison mental health unit.

Measure: Number of discharge meetings attended.

Source of Information: Contact logs of community program officers.

Significance: Improved understanding of community program needs will provide valuable information for system planning.

Fiscal Year	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	24	30	35	40

Indicator Five: Develop and maintain Community Liaison Officers.

Measure: Community Liaison Officers positions filled

Source of Information: Personnel

Significance: Peers will provide community support for patients discharged from Montana State Hospital in meeting the recommendations of the hospital discharge plan and re-integrating into the community.

Fiscal Year	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	0	2.5	2.5	5

Goal Five: Provide case management services to those persons with serious disabling mental illness.

Indicator One: Continue the implementation of strength based case management.

Measure: Number of strength based case management trainings.

Source of Information: Contact sheets

Significance: A trained workforce will further person centered planning which respects consumer rights and wishes.

Fiscal Year	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	1	2	3	5

Goal Six: **Establish processes for transitioning youth in state funded services to adulthood.**

Indicator One: Strengthen coordination between the Systems of Care Committee and Mental Health Oversight Advisory Council.

Measure: Established communication mechanism.

Source of Information: Written protocol

Significance: These two councils provide oversight of the two mental health systems. Many of the members can provide invaluable insight.

CRITERION 2: Mental Health System Data Epidemiology

Freedom Commission:

Goal 3: Consumer/Family Centered Care: *Consumers and families will have the necessary information and the opportunity to exercise choice over the care decisions that affect them.*

Transformation Activities: *Assure individualized plans of care for all consumers*
Remove disparities in access to and quality of care

Incidence and prevalence

The number of adults with serious mental illness in Montana is estimated to be 13,379 at 150% of federal poverty level and 18,820 at the 200% of FPL. This number is based on the number of adults in 2000 census data and application of a methodology developed by WICHE. According to the FY 2006 data a total of 14,404 served. This translates to a 103% penetration rate for adults at or below 150% of FPL.

Population Group	Cases	# Served	Penetration Rate	Unmet Need
Total Population	43,327	14,404	33%	67%
<200% FPL	18,8201	14,404	77%	23%
<150% FPL	13,979	14,404	103%	0%

Definition of Severe Disabling Mental Illness (SDMI)

This definition of severe disabling mental illness is based on diagnosis, duration of illness, and level of functioning. The criteria used by Montana are as follows:

“Severe disabling mental illness" means with respect to a person who is 18 or more years of age that the person meets the requirements of (a) or (b) or (c). The person must also meet the requirements of (d):

(a) has been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder at Montana State Hospital at least once; or

(b) has a DSM-IV diagnosis of
(i) schizophrenic disorder (295);
(ii) other psychotic disorder (295.40, 295.70, 297.1, 297.3, 298.9, 293.81, 293.82);
(iii) mood disorder (296.2x, 296.3x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, , 293.83);
(iv) amnestic disorder (294.0, 294.8);
(v) disorder due to a general medical condition (310.1); or
(vi) pervasive developmental disorder not otherwise specified (299.80) when not accompanied by mental retardation;
(vii) anxiety disorder (300.01, 300.21, 300.22, 300.3) or

(c) has a DSM-IV diagnosis of personality disorder (301.00, 301.20, 301.22, 301.4, 301.50, 301.6, 301.81, 301.82, 301.83, or 301.90) which causes the person to be unable to work competitively on a full-time basis or to be unable to maintain a residence without assistance and support by family or a public agency for a period of at least 6 months (or for an obviously predictable period over 6 months); and

(d) has ongoing functioning difficulties because of the mental illness for a period of at least 6 months (or for an obviously predictable period over 6 months), as indicated by at least two of the following:
(i) medical professional with prescriptive authority has determined that medication is necessary to control the symptoms of mental illness;
(ii) the person is unable to work in a full-time competitive situation because of mental illness;
(iii) the person has been determined to be disabled due to mental illness by the Social Security Administration;
(iv) the person maintains a living arrangement only with the ongoing supervision, is homeless, or is at risk of homelessness due to mental illness; or
(v) the person has had or will predictably have repeated episodes of decompensation. An episode of decompensation includes:
- increased symptoms of psychosis
- self-injury
- suicidal or homicidal intent, or
- psychiatric hospitalization.

Goal One: **To provide medically necessary mental health services to eligible persons who have Severe Disabling Mental Illness (SDMI).**

Indicator One**:** Maintain an array of community based services for adults with severe disabling mental illness.

Measure: Numerator: Number of community based services available to adults with SDMI.

Source of Information: MMIS database

Significance: Offering an array of services available to adults with SDMI allows individuals to remain in the community.

Mental Health Services Plan Recipients by Service

Services	*FY 06 Individuals*	*FY 07 Individuals**	*FY 06 Net Payments*	*FY 07 Net Payments**
Community Mental Health	*805*	*659*	*$2,289674*	*$1,690,738*
Licensed Professional Counselor	*2594*	*1885*	*$ 618,190*	*$ 390,805*
Mid-Level Practitioners	*295*	*441*	*$ 48,932*	*$ 74,665*
Psychiatrists	*1938*	*1547*	*$ 788,691*	*$ 501,954*
Psychologists	*183*	*91*	*$ 43,762*	*$ 14,540*
Social Workers	*1796*	*1462*	*$ 656,644*	*$ 287,550*
Targeted Case Management	*2657*	*2228*	*$3,388,607*	*$1,873,277*
Pharmacy Program	*3473*	*3037*	*$3,068,269*	*$2,721,478*
Total	*13741*	*11350*	*$10,902,769.00*	*$7,555,008.00*

Pharmacy program recipient and costs are based on actual paid claims.
Other service cost and recipient counts are based on encounter data.

Medicaid Mental Health Services by Services and Paid Claims

Services	*FY 06 Individuals*	*FY 07 Individuals**	*FY 06 Net Payments*	*FY 07 Net Payments**
Community Mental Centers	*1984*	*1864*	*$14,573,726*	*$13,390,748*
Inpatient Hospital	*681*	*734*	*$14,551,054*	*$4,959,000*
Licensed Professional Counselors	*3481*	*3205*	*$1,231,896*	*$1,068,647*
Physicians	*5893*	*5174*	*$503,573*	*$472,753*
Psychiatrists	*4155*	*3716*	*$1,527,152*	*$1,321,750*
Psychologists	*941*	*798*	*$252,452*	*$225,860*
Social Workers	*2152*	*1885*	*$616,445*	*$477,192*
Lab and x-ray	*429*	*361*	*$29,943*	*$27,273*
Personal Care	*247*	*245*	*$1,301,284*	*$1,276,880*

Federally Qualified Health Centers	*1262*	*1136*	*$260,321*	*$248,477*
Rural Health Clinics	*772*	*691*	*$152,172*	*$148,567*
Mid-Level Practitioners	*2516*	*2225*	*$315,997*	*$245,981*
Targeted Case Management	*3701*	*3446*	*$9,576,179*	*$8,446,088*
Outpatient Hospital	*2618*	*2577*	*$2,222,747*	*$2,358,846*
TOTAL	*13,554*	*13,150*	*$47,114,941.00*	*$34,668,062.00*

Source: ACS 701Reports and ACS Query Path Decision Support Software

** Information is not complete. Information is through July 15, 2007. Providers have 365 days to file a claim.*

The MHSP is administered through contracts with four Community Mental Health Centers for a fixed contract amount. In FY 2007, the contract total was $3,504,526.

All services are provided through a Community Mental Health Center with the exception of pharmacy services. Practitioners identified above provide services through the Community Mental Health Center.

The actual number of persons served by age and ethnicity for FY 2007 is as follows:

Age	**Female**	**Male**	**Total**
18-20 year	752	580	1332
21-64 year	9348	5306	14654
65-74 year	585	277	862
75+ year	1048	341	1389
Total	11733	6504	18237

	American Indian or Alaska Native		**Asian or Pacific Islander**		**Black or African American**		**White**		**Hispanic**	
Age	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*
18-20 years	125	68	7	2	10	5	584	472	11	16
21-64 years	1004	404	24	11	48	29	7752	4334	191	84
65-74 years	53	21	2	1	2	1	520	248	2	1
75+ years	40	16	2	0	0	3	996	311	9	3
Total	1222	509	35	14	60	38	9852	5365	213	104

CRITERION 3: CHILDREN'S SERVICES
Not applicable

CRITERION 4: Targeted Services to Rural and Homeless Populations

Freedom Commission:

***Goal 1: Mental Health is Essential to Health**: Every individual, family and community will understand that mental health is an essential part of overall health.*
***Goal 3: Consumer/Family Centered Care:** Consumers and families will have the necessary information and the opportunity to exercise choice over the care decisions that affect them.*

Transformation activities:
Reduce stigma associated with mental illness
Link mental health care with primary care
Facilitate access to and quality of care
Improve coordination of care among multiple systems
Develop culturally competent services

For planning mental health services, Montana is an entirely rural state and its mental health system is a rural mental health system. The extent to which this mental health system serves Montana's huge geographic area is impressive. The public mental health system provides professional mental health services in counties with as few as 1.66 people per square mile (Beaverhead County), and part-time professional mental health services in 26 counties with as few as 0.27 people per square mile (Garfield County).

The Eastern Montana Telemedicine Network has been operational since September 1993 and presently has nineteen partner sites in Montana and 2 sites in Wyoming. Telemedicine ensures a continuum of mental health care throughout Eastern and Central Montana. Ninety-four percent of the patients seen over telemedicine were retained in their local community. Ninety-six percent of the providers identified that consumers seen over telemedicine would have been referred out of the community if the technology had not been available. Mental health services provided include: medication review; follow up visits to monitor progress; discharge planning; individual and family therapy; emergency consultation; and employee assistance.

SOAR

Montana was selected to be one of fourteen states and/or cities for the SOAR project. (SOAR is the acronym for SSI/SSDI Outreach, Access and Recovery.) This has proven to be a highly effective training for case managers who are working with persons who are homeless and have a mental illness. This training has been offered to all case managers and supervisors in mental health and substance abuse agencies and Health Care for the Homeless staff. A total of five trainings have been offered in Great Falls, Billings, Helena and Butte for over a hundred thirty persons trained. The Helena training was offered at the Law Enforcement Academy for discharge planners from Yellowstone (Billings) County Detention Center, Montana Women's

Prison, and pre-release case managers from Butte, Montana State Prison discharge planners, Helena.

The project will be collecting and reporting on outcome data which will assess the effectiveness of Montana's plan to increase access to disability benefits. Through the SOAR project twenty persons who were homeless qualified for SSI since January 2006.

Projects for Assistance in Transition from Homelessness (PATH)

The PATH funds were competitively bid for FY 2008. The providers are South Central Mental Health Center, Western Montana Mental Health Center in Bozeman, Missoula, Butte and Kalispell, and Center for Mental Health. The contracts will be finalized for Western Montana Mental Health Center and Center for Mental Health by September. South Central Mental Health Center received their contract in July 2007.

The PATH annual report for FY 2006 was provided by Western Montana Mental Health Center in Butte, Kalispell, and Missoula; Center for Mental Health Center; and South Central Mental Health Center. The total number of persons served in FY 2006 was 1,363. Of this number 1,097 were enrolled in the PATH programs. All enrolled PATH clients received outreach and case management services.

Demographics of the enrolled PATH clients:

- Age – 26% were 18-34 years; 49% 35-49 years; and 25% 50-64 years.
- Gender – 71% were male and 29% were female.
- Race – 85% Caucasian; 11% Native American; 3% Hispanic; and 2% Black.
- Principal Diagnosis – 36% with Schizophrenia; 25% Affective Disorder; 9% personality disorder; 3% other psychotic disorder; and 27% unknown.
- Co-Occurring Substance Abuse Disorders – 40%
- Veteran Status – 7%
- Housing Status – 15% outdoors; 28% short term shelter; 5% long term shelter; 26% own apartment, dwelling; 5% hotel/SRO; 4% jail; 11% institutions; and 6% other.
- Length of Time Outdoors/short term shelter – 88 persons less than 2 days; 275 2-30 days; 29 31-90 days; 29 91-1 year; and 22 more than one year.

The PATH program will be using the Recovery Markers web based measures. It is hoped that we will be able to better track the results of case management for the homeless population as they use PATH case management services and then the mainstream mental health services. The measures that will be tracked quarterly are: living status; employment/education; symptom interference; stages of change for alcohol and drug use; and level of use of alcohol and/or drug use. In addition, the PATH program will submit all data in the Homeless Management Information System (HMIS) which is a HUD required data collection system. This will aid the agencies in getting a true picture of homelessness in Montana.

Other Homelessness Activities

Continuum of Care Point-in-Time Homeless Population and Subpopulations Chart

Indicate date of last point-in-time count: 1/31/2007

Part 1: Homeless Population	**Sheltered**		**Unsheltered**	**Total**
	Emergency	**Transitional**		
Number of Families with Children (Family Households):	83	177	16	276
1. Number of Persons in Families with Children:	258	531	60	849
2. Number of Single Individuals and Persons in Households without Children:	352	667	234	1253
(Add Lines Numbered 1 & 2) Total Persons:	610	1198	294	2102

Part 2: Homeless Subpopulations	**Sheltered**	**Unsheltered**	**Total**
a. Chronically Homeless (For sheltered, list persons in emergency shelter *only*)	53	73	126
b. Severely Mentally Ill	118	48	166
c. Chronic Substance Abuse	96	34	130
d. Veterans	206	66	272
e. Persons with HIV/AIDS	5	1	6
f. Victims of Domestic Violence	287	27	314
g. Unaccompanied Youth (Under 18)	106	9	115
Montana Survey of the Homeless 2007: http://nth-degree.com/mthomeless/svg07.html			

Notes:

- Included in Emergency Shelter: Emergency Shelter, Motels With and Without Vouchers
- Included in Transitional Shelter: Transitional facilities, Treatment, Foster Care, Staying with Family/Friends, Jail, Prison, Hospital, Other and Unknown.
- The January 31, 2007 Survey of the Homeless in Montana identified 2,117 unduplicated homeless persons. These numbers do not add to that because some information was missing.
- Persons with co-occurring disorders were identified separately from those with substance abuse and mental health disorders. The numbers of persons with co-occurring disorders have been divided evenly between the mentally ill and chronic substance abuse categories.
- Unaccompanied youth does not account for youth who are homeless but who are with families/partners of their own. This accounts strictly for youth who self-identified as being "alone." The numbers of youth who are homeless with other young people are much higher.

Part 2: Homeless Subpopulations	**Emergency**	**Trans.**	**Unsheltered**	**Total**
Youth (Under 18) who are: alone; single parents with children; with a spouse or partner and children: with spouse or partner, but no children	**67**	**118**	**14**	**199**

The Montana Council on Homelessness (MTCoH) was originally created by Executive Order by Governor Judy Martz in 2004, and continued by Governor Brian Schweitzer in December 2006. Members are appointed by the Governor, and serve 2-year terms. The mission of the MTCoH is "To *develop and implement strategies to prevent and reduce homelessness in Montana overall and to end chronic homelessness by 2014."* Homelessness rises from and is sustained by three basic factors: personal vulnerabilities; lack of affordable housing; and social policy. The newly appointed Council has been charged with reviewing, editing and approving the draft 10-year plan to address homelessness created by the initial council, and to begin implementing the plan. Numerous strategies have already been put into place in support of the draft plan, including: releasing reports on the state of homelessness in Montana; creating a website (www.MTCoH.org); initiating a listserv that receives periodic electronic newsletters; certifying three trainers in the SOAR (SSI/SSDI Outreach, Access and Recovery) process; providing SOAR training to nearly 200 case managers to date; hosting two VISTA volunteers; initiating and/or supporting access fairs for the homeless in three cities; holding memorials for the homeless persons who have died for the past two years; and engaging in numerous opportunities in venues that include television, radio and newspaper to educate the general public about the issue of homelessness in Montana. The MTCoH Coordinator has been named to the National Coalition of the Homeless Board of Directors, and is part of the committee addressing rural social policy for the homeless. The MTCoH serves as Montana's planning body for formulating and affecting change in the policies and practices that play a role in homelessness, the MHSB and PATH program have been actively involved in the Council's activities since inception and are an integral partner and resource in these efforts.

Outreach to Older Adults

The Department defines older adults as those persons who are 65 and older. At this time, MHSB does not have a targeted outreach to the older adult population. In the next year, we will investigate what other states' efforts are for outreach and will identify the most appropriate strategy for MHSB.

The South Central Mental Health Center does have an older adult outreach position. The person who provided this service has recently retired. It is hoped that in the future this position can be filled and funded.

Goal 1:	**Individuals who are homeless and have SDMI will have access to mental health services.**
Indicator One:	**Homeless persons with serious mental illness that have been identified will be enrolled in PATH.**
Measure:	Numerator: The number of persons enrolled in PATH services. Denominator: The total number of persons who are contacted by PATH case managers and have a serious mental illness.
Source of Information:	PATH annual report and Homeless Management Information System (HMIS).

Significance: PATH services increase a person's ability to access mainstream mental health services and move towards recovery.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	41%	81%	82%	85%	85%
Numerator	738	1097			
Denominator	1816	1363			

Goal 2: **Mental Health Services Bureau will participate in the SOAR project.**

Indicator One: Continue to train case managers and supervisors on SOAR**.**

Measure: The number of persons receiving training.

Source of Information: Attendance sheets from training sessions.

Significance: SOAR provides skill development for providers and improves access to appropriate services.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	130	100	100	100	100

Goal Three: **Ensure housing is available to persons with serious disabling mental illness.**

Indicator One: Increase linkage between mental health and housing agencies.

Measure: Number of contacts.

Source of Information: Contact logs

Significance: Housing is crucial for persons in recovery.

Fiscal Year	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	5	10	15

Goal Four: **Ensure training is made available to persons serving and living in frontier counties.**

Indicator One: Provide training to those providers serving frontier counties.

Measure: Number of providers who participate in the training.

Source: Attendance sheets from trainings.

Significance: Expanded availability of best practices to frontier counties will improve ability for consumers to remain in community.

Fiscal Year	FY 2008 Target	FY 2009 Target	FY 2010 Target
Number of Providers	5	10	15

Indicator Two: Provide training to peers in frontier counties.

Measure: Number of peers receiving training.

Source: Attendance sheets from trainings.

Significance: Peers who live in frontier counties are often isolated. The trainings would allow peers to have contact with others and develop a natural support system.

Fiscal Year	FY 2008 Target	FY 2009 Target	FY 2010 Target
Number of Peers	25	35	40

Goal Five: **Ensure respectful and culturally responsive services within the mental health system.**

Indicator One: Provide training framework for cultural competency.

Measure: Number of programs providing cultural competency orientation and training to their staff.

Source of Information: Self-report from programs.

Significance: Programs will be able to incorporate cultural awareness into the assessment and treatment of each consumer.

Goal Six: **Provide services to target populations.**

Indicator One: Continue the Home and Community Based Waiver services.

Measure: Number of persons served through the waiver.

Source of Information: MMIS data system.

Significance: The HCBS waiver allows persons with serious mental illness to choose to receive services either in the community or in a nursing home.

Fiscal Year	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Number of Persons	29	125	125	125

Indicator Two: Create linkages with adult protective services.

Measure: Number of contacts.

Source of Information: Contact logs.

Significance: Interagency collaboration will result in improved identification of and outreach to clients in need of services and improved coordinated care.

Fiscal Year	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Number of Contacts	204	200	200	200

Indicator Three: Implement the use of telemedicine services for psychiatric consultations with community medical doctors.

Measure: Number of consultations per month beginning January 2008.

Source of Information: Reported by providers.

Significance: Psychiatrists across the state have been overwhelmed with their full caseloads and continual crisis calls. Developing a new 24/7 on

call pool will alleviate some of the pressure. This will allow consultations closer to home, so consumers can maintain their current community support system.

Fiscal Year	FY 2008 Target	FY 2009 Target	FY 2010 Target
Number of Sites	800	1700	2000

Indicator Four: Develop 72 hour presumptive eligibility

Measure: Paid claims

Source of Information: State MMIS

Significance: Individuals who are uninsured will receive crisis stabilization services in a community setting rather than being transported to the state psychiatric hospital.

Indicator Five: Research other mental health programs targeting the older adult target population.

Measure: Outreach programs identified.

Source of Information: Report completed.

Significance: The older adult population has been identified as a target population by CMHS. This population has often been ignored in outreach efforts.

CRITERION 5: Management Systems

Staffing

The Mental Health Services Bureau has 17.5 FTE. This includes three licensed clinicians that oversee clinical program development and standards, two quality assurance professionals, six regional program officers, a mental health planner, five half-time peer support specialists, and two operations support staff, and a bureau chief.

Five licensed mental health centers in conjunction with private providers provide the services for adults with severe disabling mental illness. The Medicaid providers that are enrolled and have billed in the last year include 184 psychologists, 207 social workers, 445 licensed professional counselors, and 183 (50 of these practice out of state) psychiatrists.

First Health provides two contracted adult care coordinators. These professionals work closely with the state hospital and providers to ensure appropriate community placement.

DPHHS has a Drug Utilization Review Board to improve prescribing practices for mental health prescription drugs. The drug utilization review board contracts to provide education on best practices for prescribing. This has proven to be an effective quality management practice in other states.

Efforts to recruit and retain qualified professionals to work in Montana's public mental health system continue to present a challenge for provider agencies across the state. A practicum is available for nursing students at Montana State Hospital as well as internships and field placements for students in psychology, counseling, and recreation therapy. Additionally, licensed mental health centers provide the opportunity for students who have completed the academic requirements for licensure to work under supervision for the required period of time before becoming eligible for the licensing examination.

Often mental health consumers will migrate to the larger cites for services and have currently outstripped the ability of these communities to serve the growing needs. Even our larger communities are finding it very difficult trying to recruit new mental health professionals. The HPSA designation that currently covers our smaller communities has been of little help in recruiting new psychiatrists and mid-levels. If opening this up to the larger communities can better support them in recruiting mental health professionals, then this could increase the capacity of the state wide system of care where it is needed most in Montana.

AMDD is working with Health Resources Division (Children's Mental Health System), Primary Care Office and the SAA's to re-designate the "Health Provider Shortage Area's (HPSA)" to include the more populated counties in the state (Yellowstone, Lewis & Clark, Flathead, Missoula, Gallatin and Cascade). Currently these counties are not designated as HPSA's but are serving many of the mental health needs from their counties and the rest of the state.

Training of Consumers and Family members

Montana invests resources to support the training opportunities for consumers, family members, providers, and other stakeholders. The Department will continue it's funding for education programs provided by NAMI for consumers, family members, and providers. MHSB provides additional funds for the annual Mental Illness conference. Over 150 consumers attend this conference each year.

The MHSB will provide additional WRAP training and anticipate sponsoring a Leadership Academy in spring of FY 2008.

Training of Providers

MHSB contracts with Zialogic to provide ongoing consultation and technical assistance for the implementation of Co-Occurring Capability among providers in Montana. Clinical training activities have included motivational interviewing, stages of change, and integrated treatment planning.

Crisis Services and Training

The Mental Health Services Bureau community program officers work in local communities to plan for and implement crisis services. The MHSB works closely with the SAAs, LACs, Mental Health Oversight Advisory Council, county and city officials, providers and other stakeholders to develop and improve crisis services.

The Billing Community Crisis Center is example community collaboration. The Billings Crisis Center and MHSB sponsored Crisis Intervention Team (CIT) training in May and again in September. NAMI and the Helena Local Advisory Council (LAC) sponsored CIT training in Helena. The Missoula community is investigating the possibility of sending a team to Memphis to be trained as trainers. This would establish CIT trained officers in each SAA.

Another model used for crisis is the Crisis Response Team (CRT). Members of the team are dedicated clinicians whose job is to respond to crisis calls in the community, at the local emergency room, or in the detention center. Teams are operational in Kalispell, Missoula, Butte, Helena, and Bozeman/Livingston.

Each of the local mental health agencies and LACs train first responders in mental health crisis. Many of the emergency rooms contact either the CRT or trained CIT officers when a person in a mental health crisis presents themselves.

Consumer and Family Member Participation in Planning and Decision-making

MHSB will continue its long-standing commitment to collaboration with consumers and family members. The Mental Health Oversight Advisory Council, Local Advisory Committees, Service Area Authorities, and ongoing relationship with the Mental Health Ombudsman are examples of this collaboration.

By law SAAs are required to have 51% consumer and family member representation on each board. Consumers and family members are encouraged to participate in decision making at the local level. The LAC each determines the allocation of community mental health resources.

Data Infrastructure Grant

The Data Infrastructure Grant (DIG) was awarded to states to assist in the development of a data infrastructure to collect specific data on the population served in the public mental health system. The Uniform Reporting System allows for the exchange of state and federal data for planning purposes and demonstration of effectiveness. AMDD has entered into data sharing agreements with the Department of Justice as well as other agencies within the Department. In FY08, AMDD will allocate a portion of its DIG funds to assist providers of children's services in gathering and submitting data to be included in federal reporting requirements.

Use of Block Grant Funds

The CMHS Mental Health Block Grant allocation for Montana is estimated to be $1,236,408. Block grant funds are used for services for adults with severe disabling mental illness and youth

with serious emotional disturbance. The program activities supported by block grant funds are part of the Mental Health Services Plan and all funds will be used to purchase community-based services.

Federal block grant and general funds are used to contract with licensed mental health centers to provide community services to those persons that are eligible for MHSP. General funds are used for emergency pharmacy funds for each contracted mental health center. AMDD will be transforming the Mental Health Service Plan (MHSP) from a fixed contracted amount to a fee for service during FY2008. The provider network will be expanded January 2008 to include any willing provider who has prescriptive authority. Additional expansion of the provider network and implementation of fee-for-service and consumer choice should be completed by June 30, 2008.

Funds (FY 2008)	**MHSP**	**Block Grant**	**Pharmacy**
Eastern Montana MHC	$2,212,760	$158,650	$ 6,829
Center for Mental Health MHC	$ 466,595	$256,281	$16,608
South Central MHC	$ 479,316	$268,485	$13,923
Western Montana MHC	$ 963,955	$536,970	$34,020
TOTAL	$2,212,760	$1,220,386	$71,380

Table 4

FY 2008 – FY 2010 MHBG Transformation Expenditure Reporting Form

State Transformation Activity	FY 2008 MHBG Planned Expenditure Amount	FY 2008 Other State Funding Source Amount
Improving **coordination** of care among multiple systems		$643,557
Support for **culturally competent** services		$152,050
Involving **consumers and families** fully in orienting the MH system toward recovery	$247,796	$687,677
Support for **consumer- and family-operated programs**, including Statewide consumer networks		$122,247
Services for **co-occurring** mental and substance use disorders		$5,844,504
Eliminating **disparities** in access to and quality of care	$495,592	$21,281,933
Support for integrated **electronic health record** and personal health information systems		$3,449
Improving consumer access to **employment and affordable housing**		$3,449
Provision of **Evidence Based Practices**	$123,900	$11,138,790
Aligning **financing** for mental health services for maximum benefit		$3,779,902
Supporting **individualized plans of care** for consumers		
Supporting use of **peer specialists**		$290,449
Linking mental health care with **primary care**		
Supporting **school** mental health programs		
Supporting early mental health **screening,** assessment, and referral to services		
Suicide prevention		$403,449
Supporting reduction of the **stigma** associated with mental illness		$172,804
Use of health **technology** and telehealth to improve access and coordination of mental health care		$1,003,449
Supporting **workforce development** activities		$121,006
Other (specify) Mentally Ill Offenders Drugs/Services Least restrictive care		$1,321,647 $5,858,105

Operating costs		$1,222,840

Goal One: **Expand access to crisis services**

Indicator One: Develop 72 hour presumptive eligibility.

Measure: Services available

Source of Information: AMDD report

Significance: Individuals who are uninsured will receive crisis stabilization services in a community setting rather than being transported to the state psychiatric hospital.

Indicator Two: Local communities will provide training of emergency health providers (first responders).

Measure: Training provided to emergency health providers.

Source of Information: Information provided from Community Program Officers, LACs and SAAs.

Significance: Often the emergency room or law enforcement are the first intervention for persons in psychiatric crisis.

Indicator Three: Encourage training of law enforcement officers.

Measure: Number of officers trained in Crisis Intervention Team (CIT)

Source of Information: Law enforcement academy and NAMI records.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	30	93	80	80	80

Indicator Four: Create a position for statewide suicide prevention coordination.

Measure: Position hired.

Source of Information: Personnel

Significance: Statewide coordination of all suicide prevention programs is more efficient and cost effective and will improve the state's ability to initiate a statewide prevention effort.

Indicator Five: Participate in suicide prevention training.

Measure: Staff trained in ASSIST

Source of Information: Attendance of training.

Significance: Improved ability for suicide prevention and community awareness.

Goal Three: Support and enable persons with severe disabling mental illness and family member participation.

Indicator One: Maintain a minimum of 51% persons who are primary consumers and family membership on Mental Health Oversight Advisory Council.

Measure: Numerator: The number of family and consumer members
Denominator: The total number of members.

Source of Information: Advisory Council roster of membership

Significance: Consumers and family members are critical to the development of mental health services in Montana.

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	56%	57%	51%	51%	51%
Numerator	17	17			
Denominator	29	30			

Indicator Two: Partner with the Local Advisory Councils (LAC) across the state.

Measure: Participation at LAC meetings by community program officers.

Source of Information: Summaries of reports from LACs, community program officers and regional planner.

Significance: Staff support will assist in local system development.

Indicator Three: Partner with Service Area Authorities (SAA) across the state**.**

Measure: Participation at SAA by community program officers and regional planner.

Source of Information: Summaries of reports from SAA, community program officers and regional planner

Significance: Ensuring the success of the SAAs further the goals of system development.

Goal Four: **Support education for persons with severe disabling mental illness, family members, and providers**

Indicator One: Contract with NAMI to provide the following training:

a) Family to Family education program offered in a minimum of three communities in Montana
b) Support Group Facilitator training
c) "In Our Own Voice" Living with Mental Illness presentations
d) Provider Education Course offered in communities
e) Peer to Peer Recovery Course

Measure: a) Number of courses and training provided

Source of Information: Report from NAMI trainers

Significance: Education on severe mental illness supports the recovery process.

Fiscal year	FY 2006 Actual	FY 2007 Actual	FY 2008 Target	FY 2009 Target	FY 2010 Target
Number of Family to Family	3	9	5	5	5
Number of Support Group Facilitator	0	1	0	1	0
Number of "In Our Own Voice"	15	15	20	25	30
Provider Education	2	1	2	2	2
Peer to Peer	3	5	5	6	6

Indicator Two: Continue Wellness Recovery Action Plan (WRAP) training.

Measure; Number of persons trained.

Source of Information: Attendance sheets

Significance: Increased number of consumers and family members who actively participate in recovery activities

Fiscal Year	FY 2007 Target	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	125	125	125	125

Indicator Three:	Issue request for proposals for recovery initiatives.
Measure:	Number of proposals received and funded.
Source of Information:	Information obtained by review committee.
Significance:	Provides an opportunity for community development of programs that support recovery activities at the local level
Indicator Four:	Provide trauma informed training to the public mental health system.
Measure:	Training provided by late FY 2008
Source of Information:	Attendance sheets
Significance:	A vast majority of persons who have mental illness have suffered from trauma in their life. To have providers trained would help reduce re-traumatizing persons in their care.
Goal Five:	**Provide training to community mental health providers and state approved alcohol and drug programs.**
Indicator One:	Organize regional trainings with change agents**.**
Measure:	Persons attending training.
Source of Information:	Attendance and letters of invitation
Significance:	To build capacity within the state.
Indicator Two:	Develop statewide training plan for co-occurring capable services.
Measure:	Training plan developed and implemented.
Source of Information:	Written plan
Significance:	Provide a roadmap for the co-occurring initiative and will allow the state and stakeholders to evaluate the initiative.
Goal Six:	**Collect and utilize data from the recovery markers.**
Indicator One:	Have programs begin submitting data July 1, 2007 upon intake or treatment plan review.

Measure:	Number of clients for whom recovery markers have been entered into the data base.
Source of information:	Data base
Significance:	Providers will utilize the outcomes to determine the individual needs of consumers.
Indicator Two:	Train supervisors on the usefulness of the recovery marker data for care management and long-term planning for agencies.
Measure:	Training held and number attended
Source of Information:	Attendance sheets from training.
Significance:	This moves the mental health system to a recovery based and person centered system.
Indicator Three:	Develop, distribute and assist in interpreting reports for MHSB and the programs.
Measure:	Number of reports developed and distributed.
Source of Information:	Reports
Significance:	The reports will help AMDD and mental health providers focus on outcome measurement.
Goal Seven:	**Collect data from the mental health centers for performance measures.**
Indicator One:	75% of data fields completed in performance data submissions by providers.
Measure:	Data fields completed and accurate.
Significance:	With more accurate and complete data we can better measure the effectiveness of the mental health system.
Indicator Two:	Develop benchmarks for improved completion of data fields.
Measure:	Baseline for benchmarks developed.
Significance:	With more accurate and complete data we can better measure the effectiveness of the mental health system.

Goal Eight:	**Allocate Community Mental Health Block Grant for persons with severe disabling mental illness.**
Indicator One:	Block Grant funds of $1,218,982 will be included in the contracts for services to adults eligible for the Mental Health Services Plan in FY 2008. $20,000 of the block grant will be for the MHSP services for youth.